STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035190	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Catalina Post Acute and Rehabilitation	2611 North Warren Avenue Tucson, AZ 85719

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, review of the clinical record, and review of facility policy and procedure, the facility failed to ensure one resident (#50) was provided care and services to meet professional standards regarding following physician orders for assessment of a resident post-fall. The deficient practice could lead to an injury being missed and a delay of care provided to a resident. -Findings include: Resident #50 was admitted to the facility July 21, 2022 and discharged on August 19, 2022, with diagnoses that included metabolic encephalopathy, unsteadiness on feet, need for assistance with personal care, cognitive communication deficit, altered mental status, unspecified psychosis not due to a substance or known physiological condition, and bipolar disorder. An admission MDS (minimum data set) assessment, dated January 16, 2025, revealed the resident had a brief interview for mental status (BIMS) score of 8, indicating the resident had moderately impaired cognition, with no indicators for mood or behaviors identified. A Care Plan, initiated July 19, 2022 included a focus for anticoagulant therapy (Lovenox) related to deep vein thrombosis (DVT). Interventions included monitor/document/report to medical doctor as needed for signs or symptoms of anticoagulant complications. Further review of the care plan revealed a focus of at risk for falls related to unsteadiness on feet, had fall July 21, 2022 with bruising to right eye. Interventions implemented were first aid applied to bruising to the right eye and the resident was sent to emergency room for evaluation for change of elevation on July 21, 2022. A progress note with an effective date of July 21, 2022 at 03:00 am, revealed that the patient got up to the bathroom, returning back to bed, fell and hit her forehead on the counter, refused to have vitals done, has long hair falling over her face and does not wish it tied back. Vital signs stable. 135/90. An eMar-Medication Administration note dated July 21, 2022 at 03:09 am, revealed Acetaminophen Tablet give 650mg by mouth every six (6) hours as needed for pain. 650mg administered. A progress note with an effective date of July 21, 2022 at 06:45 am, revealed the following: has a bruise below right eye, states left upper forehead above left eye hurts, area red, ice was applied to site. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated July 21, 2022 at 07:13 am, revealed the following: Notified by primary nurse that resident had an unwitnessed fall overnight and hit her head, reports no loss of consciousness. Upon assessment there was no visible injury. Resident recalls walking to restroom and losing balance, hitting her head on counter, then walking herself back to bed. Pupils round and reactive, vital signs stable. Resident alert and oriented x4, reports a headache, no pain otherwise. Resident asks that nursing not notify her son. Director of Nursing (DON) notified, AMR dispatched, ETA one hour. Report called to medical center. A physician order dated July 21, 2022, was written for a change of condition for hitting head while taking self to bathroom, document in progress notes every shift for three days. An additional order was also written for Enoxaparin Sodium Solution Prefilled Syringe 40MG/0.4ML Inject 40 mg subcutaneously one time a day for clotting prevention. Review of the neurological check document dated July 21, 2022, revealed that the neurological checks were implemented at 3:00 am and ended 08:45 am. The document further revealed that the resident refused neurological checks at 3:15 am, 3:30 am, 3:45 am, 4:15 am, 4:45 am, 5:15 am and 5:45 am, with the re-implementation of neurological checks at 7:45 and 8:45 am. No evidence was found to indicate that neurological checks were conducted after 8:45 am, as ordered by the provider. The document also revealed that the resident was sent to the hospital at 9:45 am. A progress note dated July 21, 2022 at 07:55 am, revealed the following:: After further evaluation, son notified at 07:50 am due to resident mentation and medical power of attorney status (MPOA) and a voicemail was left with name, title and brief description of events, call back number provided for any questions. A progress notes effective date July 21, 2022 at 09:36 am, revealed that the patient left via stretcher via EMR (emergency medical) with 2 attendants at 9:30 am. An IDT progress note effective date July 21, 2022 at 10:51 am, revealed a note text stating the resident had an unwitnessed fall the morning of July 21, 2022 at approx. 0300 am. The note indicated that the resident was returning from the restroom when she lost balance and hit her forehead on the bathroom counter. The note further revealed that the resident denied loss of consciousness and returned to bed. No visible injury assessed, pupils' equal round and reactive, orientation within baseline, AVSS (afebrile, vital signs stable), resident denied additional vital sign collection for neuro assessments. The provider was notified, received order to send the resident to the ER for evaluation, DON and MPOA notified. Interventions included: Bed in lowest position and non-skid socks and the care plan was updated. Review of the facility 5-day report noted the incident occurred on July 21, 2022, and included the certified nursing assistant (CNA/Staff #174) was making last round at 0500 and found the resident sitting on the side of bed. The resident informed the CNA that she had gone to the bathroom and lost her balance, striking her head on the counter. The report included that the nurse (RN/Staff #3) was notified and neuro checks were initiated, the resident complained of pain above the left eye, ice was applied, the provider notified, and orders received to send the resident to hospital for CT (computed tomography) scan. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility internal investigation report dated July 21, 2022 revealed no injuries at time of incident and ambulatory with assistance. Review of the emergency department (ER) pertinent report dated July 21, 2022 at 9:56 am, revealed that the patient was a [AGE] year-old woman with a history of TIAs, bipolar disorder. and other undefined encephalopathy who presented to the ER as a trauma yellow. The report incuded that the resident with questionable altered level of consciousness, reportedly had an unwitnessed fall at 3:30 AM this morning, and was taking prophylactic Lovenox. The report further revealed that per chart review, the resident had been seen at the hospital approximately 11 days ago for another fall and that imaging at that time was negative but she was sent to the care center for rehabilitation. The report revealed that history was somewhat limited as the patient had difficulty focusing, but she endorsed pain in her back but nowhere else, she did not remember the events of the fall, had difficulty following commands but per chart review, it is difficult to ascertain if this is chronic or new since her accident. An interview was conducted with a Registered Nurse (RN / Staff #142) on June 20, 2025, at 10:36 am who stated that the facility's process for assessing residents who sustain an unwitnessed fall on anticoagulants was to immediately conduct neuro checks, make sure the resident was at their baseline, and answered questions appropriately, asses for any head injuries, nausea, pain with movement, palpitations and vital signs. The RN also stated that the assessment would include immediately notifying the doctor, the DON, family member-leaving a message if no response and with any head injury will call 911. The RN also stated that she would educate the resident if they should refuse neuro checks of possible death and if they continued to refuse the neuro checks would notify the doctor, DON (Director of Nursing), and family immediately and document the refusal and notification. The RN further stated that the resident would be sent to the hospital for a CT scan, if the resident was taking any blood thinner, including aspirin, and that staff are always able to contact the DON or the Medical Director if the resident's provider would be unavailable. The RN stated if the doctor decided not to send the resident to the hospital, the order would be documented in progress notes. The RN also stated any resident with an observable head injury with complaints of pain and/or redness would need to be sent to the ER immediately. The RN further stated that the risks of not following the process for an unwitnessed fall with observable head injury, complaints of head pain and receiving anticoagulant therapy could result in possible death for the resident. An interview was conducted with the DON (Staff #15) on April 3, 2025, at 10:15 am, who stated that the resident should be assessed by a nurse if an unwitnessed fall occurs or if the resident may have hit their head, neuro checks should be started, and the provider notified. The DON stated if the resident is not their own responsible party, then the responsible party is notified and depending on what the doctor has ordered, the resident will be sent to the hospital for a CT scan. The DON further stated if a resident should refuse neuro checks staff would try again, educate about the risks and benefits and notify the doctor. The DON also stated that all documentation of contacts should be in the progress notes, and the doctor should be notified of the fall immediately. Review of the facility policy titled, Resident Assessment: Fall Management System, revised May 2021 revealed that it is the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. When a resident sustains a fall, a physical assessment/evaluation will be completed by a licensed nurse, with results documented in the Nursing Progress Notes and the attending physician and family/ responsible party as applicable shall be notified of the fall and the resident status.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on resident interview, policy review, and staff interview, the facility failed to ensure a Registered Nurse (RN/Registry Staff # 467), who was from a staffing agency and not employed by the facility directly, had the specific competencies and skill sets necessary to care for residents' needs. This failure had the potential to affect all residents assigned to the RN's care during her shift. Findings include: Review of the facility 5-day report revealed alleged perpetrator RN (Registry/ Staff # 467) had been contracted through a nursing registry. Facility eMAR documents revealed that the RN (alleged perpetrator) worked at the facility as a registered nurse starting August 26, 2022 and no additional documentation for scheduled shifts worked in August 2022. Further review revealed the registry RN was scheduled to work the following days; September 2,3,4,9,10.11.16.17, 18, 23,24,25, and 30 for the 6PM-6AM shift. The facility became aware of the alleged perpetrator on September 19, 2022 when the Dietary Supervisor (Staff/#56) alerted the Director of Nursing (DON/Staff #147) of recognizing the alleged perpetrator registry Staff # 467 as a potential candidate, when applying for a position in dietary/housekeeping. The DON attempted to verify the Arizona license for the agency RN and was unable to find licensure. The facility contacted the head of the nursing agency who was unable to verify the RN's license or contact the RN. The facility investigation determined that the alleged perpetrator RN (Registry/Staff # 467) had impersonated a registered nurse using another individuals RN nursing license. The report revealed that the facility substantiated the allegation of other unlicensed nurse providing care in the facility. Review of the Registry Agreement effective date February 2, 2022 revealed that Registry shall provide temporary clinical staff. Staff shall be properly licensed and qualified healthcare professionals duly trained and certified for their profession. Registry shall be solely responsible for screening staff to ensure suitability to perform the assignments as requested by the facility Applicable eligibility documentation for each staff personnel assigned to facility shall be provided prior to any staff beginning a shift at the facility. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on June 19, 2025 at 2:10 PM with the Human Resources Manager (HR Manager/Staff #118) who stated her role is to assist with the hiring process for all staff, including registry staff. The HR Manager stated the process for registry staff is to have them sign an orientation packet, but agencies will hold their staff certifications. Staff #118 stated the facility will verify any registry staff license, depending on their position through the State Board of Nursing, verify fingerprint cards and Adult Protective Services. The HR Manager stated as an registry RN, alleged perpetrator Registry RN (Staff # 467) license would have been verified through the State Board of Nursing. The HR Manager stated that she did not know the complete process for registry staff during 2022 and 2023, but the facility used a contingency checklist during that time frame. The HR Manager explaind that the Contingent Worker Checklist included online verification for Certified Nursing Assistant (CNA), Licensed Practical Nurse (LPN) and Registered Nurse (RN), Tuberculin Test, Arizona Fingerprint Card (online verification), and Background and Drug Screen (run by the registry). Staff #118 stated she looked for the document, when state requested documentation but it appeared that one was not completed for registry staff #467. She also stated that there is no documentation that the process was completed for registry staff #467. The HR Manager stated it would be her assumption that the checklist for registry staff #467 should have been completed before working on the floor with any resident. She also stated the facility does employ agency staff and current practice is the same as in 2022 with the completion of the orientation packet for agency staff and oversees to ensure that any registry staff have their license that are verified and current and are registered with the State Board of Nursing. Staff #118 stated the risks of having unlicensed individuals working as nurse pose a harm to our patients. An interview was conducted on June 20, 2025 at 11:34 AM with the Director of Nursing (DON/Staff #147) who stated registry (staff #467) had worked at the facility without a verified license. The DON stated verified nursing licenses through the State Board of Nursing, unless they are with and agency then the agency provides their own file on their licensed staff. A request was made for a copy of the nursing license for registry staff #467. The DON stated when registry staff #467 worked for the facility, the facility did not have a cross check in place for verification of licenses. The DON stated it is her expectation that all licensed staff, both facility and agency have licensure that are active. The DON stated the risks of working as a nurse without a license can cause harm to a resident or provide the resident with the wrong medications. Review of the facility policy titled, Nursing Services: Sufficient Staff, revised May 2022 revealed that it is the policy of the facility to have sufficient nursing staff with the appropriate competencies and skillsets to provide nursing and related services to promote resident safety and attain or maintain the highest practicable mental, psychosocial well-being of each resident, as determined by resident assessment and individual plans of care and considering the number, acuity and diagnosis of the facility's resident population in accordance with the facility assessment.